114CSR79

LEGISLATIVE RULE
INSURANCE COMMISSIONER

SERIES 79
GROUP LIMITED HEALTH BENEFITS PLANS

Section

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§114-79-1. General.

1.1. Scope -- This rule establishes guidelines and procedures under which the Commissioner may approve group limited health benefit plans.

1.2. Authority -- W. Va. Code §§33-2-10, 33-16F-3 and 33-16F-5.

1.3. Filing. --

1.4. Effective Date. --

§114-79-2. Applicability.

2.1. This rule applies to all group limited health benefit plans issued pursuant to article sixteen-f, chapter thirty-three of the West Virginia Code and to all insurers offering such plans as of the effective date of this rule.

§114-79-3. Definitions.

3.1. "Commissioner" means the West Virginia Insurance Commissioner.

3.2. "Group limited health benefits plan" means a plan as defined in W. Va. Code §33-16F-2.

3.3. "Part-time employee" is an employee who is employed to work less than the number of hours each week that is worked by a full time employee at the employer's business. An insurer may set limits for hours a part time employee may work and be eligible for its group limited health benefits plan.

3.4. "Seasonal employee" is an employee who is employed to work less than the full calendar year at an employment activity that is determined by seasonal or calendar changes.

3.5. "Temporary employee" is an employee whose term of employment has a defined time of termination that is less than permanent.

§114-79-4. Rate Filing.

4.1. All of the provisions of 114CSR26 apply to group limited health benefits plans except 114CSR26-1.

§114-79-5. Form Filing.

5.1. All of the provisions of 114CSR67 apply to group limited health benefit plans.

§114-79-6. Eligibility.

6.1. A group limited health benefits plan may only cover employees in a class of employees that comprises part-time, temporary or seasonal employees that (i) are ineligible for coverage under any of the employer's group health benefits plans, or (ii) are employed by an employer that does not offer a group health benefits plan to any of its employees.

§114-79-7. Benefits.

7.1. Every policy issued hereunder shall have an annual maximum benefit of at least three thousand dollars per covered person. The annual maximum benefit may hereafter be changed by order of the Commissioner.

7.2. Every policy issued hereunder shall provide benefits for at least the following services:

a. Emergency care.

b. Hospital benefits, including physician services while in the hospital.

c. Outpatient benefits, including lab and diagnostics.

d. Preventive care benefits.

e. Primary care benefits.

7.3. Every policy that does not cover prescription benefits as part of its basic coverage shall offer prescription benefits coverage as an option.

§114-79-8. Severability.

8.1. If any provision of this rule is held invalid, the remainder of the rule shall not be affected thereby.